



California Council of Community Mental Health Agencies

Representing Non-Profit Community Mental Health Agencies Throughout California

MEMORANDUM

Board of Directors

PRESIDENT

John Buck

Living Point Community Programs
Sacramento

VICE PRESIDENT

Lynn Brandstater

Verdugo Mental Health
Glendale

TREASURER

Gladys C. Lee LCSW

Pacific Clinics
Arcadia

SECRETARY

Elizabeth Pfromm MPA

Los Angeles Child Guidance Clinic
Los Angeles

MEDIATE PAST PRESIDENT

David Camara LCSW

Henrietta Weill Memorial Child
Guidance Clinic
Bakersfield

PROGRAM

Olivia Loewy PhD

Verdugo Mental Health
Glendale

Katherine Mason MSW

Catholic Charities
San Jose

PUBLIC POLICY

F. Jerome Doyle MSW

MQ Children and Family Services
Campbell

MEMBERSHIP & PUBLIC RELATIONS

Barry Schoer

Sanctuary Psychiatric Centers
of Santa Barbara
Santa Barbara

MEMBERS-AT-LARGE

Jim Balla MHA

Portals Mental Health
Rehabilitation Services
Los Angeles

Kita Curry PhD

Didi Hirsch Community
Mental Health Center
Culver City

Steven Elson PhD

Casa Pacifica
Camarillo

Mary Hargrave PhD

River Oak Center for Children
Sacramento

Ian Hunter PhD

San Fernando Valley Community
Mental Health Center
Van Nuys

Roy Marshall

Child and Family Guidance Center
Northridge

Za Thompson MA, MFT

ALLIANCE for Community Care
San Jose

Miguel Valencia PhD

Gardner Family Care Corporation
San Jose, CA

EXECUTIVE DIRECTOR

Rusty Selix

DATE: March 11, 2004

TO: Carol Hood, Department of Mental Health

FROM: Rusty Selix, Executive Director

RE: Medi-Cal Waiver - Issues affecting Mental Health Services

The Governor's January Budget proposes a comprehensive waiver of federal requirements regarding the Medi-Cal program. Applied to mental health services, we believe that this type of proposal will not have its intended effect of saving money but instead will result in delaying care particularly for children with potentially disabling mental illnesses. This leads to significantly increased costs when they eventually receive care. We have only limited comments on what is proposed but would like to suggest an alternative approach based upon prevention and early intervention.

DO NOT ELIMINATE AN ENTITLEMENT FOR ANY GROUP OF CHILDREN

Numerous studies have shown that children suffering from serious emotional disturbances will cost more if their mental health treatment is delayed or denied than the cost of that care. Limiting Medi-Cal eligibility will mean that for many children they won't have access to care through their Medi-Cal entitlement until their condition puts them in a position to where they become eligible through another entitlement such as out of home placement, special education or the juvenile justice system. In fact, that is the most common way that children enter the public mental health system.

MEDICAL NECESSITY RE-DEFINITION RAISES COMPLEX QUESTIONS

We haven't seen any written language on the administration's proposal to create a new definition of medical necessity as applied to mental health services under Medi-Cal for children, the so-called EPSDT or Early Periodic Screening Diagnosis and Treatment Program. We've been told that the objective is to ensure that children who don't have very severe conditions only receive modest services. As a policy statement, we cannot disagree with this, but we are reluctant to authorize the Department of Health Service and the Department of Mental Health to pursue such a waiver without prior legislative approval of the precise proposal and an opportunity for all stakeholders to ensure that the proposal works as stated and doesn't have unintended consequences of denying necessary and appropriate care.

PREVENTION AND EARLY INTERVENTION

EPSDT is the state and federally funded entitlement to care for children. Unfortunately, for mental health, the first four letters Early and Periodic Screening and Diagnosis are ignored. Community mental health agencies, which are now providing nearly \$1 billion in mental health services to Medi-Cal children under this program, virtually never have a child referred to them through primary care. There is no evidence that primary care physicians are complying with the mandate of ensuring that there is early and periodic screening and diagnosis.

FAIL FIRST SYSTEM

Rather, for access to mental health services, children only receive community mental health services when they have hit rock bottom, such as being hospitalized (often due to a suicide attempt), placed into the juvenile justice system, removed from their home, or removed from their classroom (and placed in special education or non-public schools). Studies show that it is often six years after the initial onset of a mental illness before children receive these mental health services.

It doesn't take much to realize that the cost of care and the likelihood of restoring a child to age appropriate success in school, home and in society are significantly diminished when there is such a delay in care.

It is not difficult to recognize the symptoms of a child who is at risk for a potentially disabling mental illness. However, it does require a concerted effort, as on their own parents are not likely to seek mental health treatment. Both stigma and lack of education prevent this.

THE PRIVATE SECTOR MUST ALSO PARTICIPATE

Besides greater efforts to ensure compliance with EPSDT among Medi-Cal enrolled children, the state should be working to ensure that all children receive timely evaluation when they are at risk of any mental health problems and the state legislature could impose this obligation on private health plans, Healthy Families and others. While private insurance tends to pay for 60% of most health care, it only pays for 40% of mental health care. There is a pattern of private health plans, even after the passage of mental health parity laws, of referring children to publicly funded programs and refusing to offer the comprehensive mental health care that is needed. Moreover, there appear to be no financial incentives or obligations for health plans to ensure that mental health problems are recognized early and treated when that can be done at very little cost.

Attached is a recent article from the *Wall Street Journal* showing that in two European countries - Norway and Denmark, a modest investment of \$1 per capita resulted in significantly earlier treatment for disabling mental illnesses, significantly reducing the cost and duration of treatment. These types of investments need to be encouraged and any restructuring of Medi-Cal and other access to mental health services needs to be built around these principles of prevention and early intervention.

EDUCATION

Finally, we note that at no cost high school curricula could be revised to ensure that high school students and adolescents (about to become adults and parents) are properly educated about the symptoms of severe mental illnesses, the treatability of these conditions and the potential serious consequences (i.e. suicide or the leading cause of disability) when potentially disabling mental illnesses are not treated in a timely manner.

CONCLUSION – ALTERNATIVE APPROACH – A DEMONSTRATION GRANT

In conclusion, we point out that the proposals stated appear to simply be a cost shift from Medi-Cal to other public expenditures and are not likely to save money. The best way to save money in mental health treatment is to focus on prevention and early intervention. This would have modest short-term costs and significant long term savings.

The savings would go beyond MediCal but also cover other federal programs such as SSI, Medicare and Title IV-E (foster care). The largest federal expenditures on mental health are for SSI. The federal government also has a defacto policy of ignoring mental illness until someone becomes disabled.

We propose that the state pursue a course similar to one now being pursued by Minnesota which is seeking a demonstration grant to expand Medicaid disability to people with mental illnesses who aren't yet on SSI – but are at risk (such as those experiencing a first psychotic hospitalization or a suicide attempt).

This proposal is based upon future federal savings not just in Medicaid but also SSI and Medicare. There are undoubtedly other ways to access more federal funds to develop a Prevention and Early Intervention Program. That is the direction we would urge in restructuring mental health services under MediCal.

Wall Street Journal
HEALTH
By: Robert McGough

Early-Detection Education Effort Benefits Schizophrenia Patients

A team of Scandinavian and U.S. scientists found that an educational campaign about the signs of schizophrenia gets patients into treatment while they have a better grip on reality and leads to a measurably better condition three months after beginning treatment.

Schizophrenia is a highly debilitating mental illness often involving hallucinations (such as disembodied voices), delusions, paranoia, confused thinking and difficulty sleeping.

An estimated 1% of Americans slide into the mental illness in their lifetime. The frequency of first indications of the disease, which is lifelong, usually peaks in the early 20s for men and in the mid to late 20s for women, though it can strike earlier or later.

The study, published last month in the Archives of General Psychiatry, looked at patients in four public-health districts in Norway and Denmark who entered initial treatment for schizophrenia.

Two of the districts sponsored an ambitious campaign encouraging early detection of schizophrenia, including visits, seminars and other communications with general practitioners, newspaper, radio and cinema advertisements, mailings to all households and a phone number to call for a diagnosis team. The other two districts didn't receive the early-detection campaign. There were about 250,000 to 300,000 people total in the two communities with the early-detection campaign, and a similar number in the other two.

Overall, 281 patients reporting initial psychotic episodes gave informed consent to be included in the study.

The study found that, in the early-detection districts, the median length of time that a patient spent with untreated psychosis before getting treatment was five weeks. That was less than one-third the length of time for patients in the communities without an early-detection campaign, whose median time before getting treatment was 16 weeks. (The median is the number at which half of the sample is greater and half of the sample is less.)

Thomas McGlashan, a psychiatrist at Yale University School of Medicine, and senior author of the study, said the longer the delay in treating a "first psychotic break," or first onset of the disease, the more severe the symptoms and disability of the patient. The illness is gradual, and in the initial weeks or months a person may still be aware that delusional thinking or hallucinations are in fact not real; that ability to distinguish is often lost as untreated illness progresses.

"In the earlier-detected health-care sector, the average person who's having a first psychotic break is less severely ill and is at a point where they're still functioning reasonably well," Dr. McGlashan said. For instance, those people might still be employed or attending school when their illness is detected. The average patient in the regions without an early-detection campaign were in worse shape, he said.

Treatment consisted of antipsychotic medicines, individual psychotherapy, and multifamily groups focused on dealing with the disorder. In most instances, the patients were hospitalized. After three months, patients in both groups improved, but the early-detection patients on the whole continued to fare better.

William Carpenter, director of the Maryland Psychiatric Research Center and a psychiatry professor at the University of Maryland, said the study shows that early detection can be built "into a system of care, and having done so makes a difference in the treatment of people with the disease." There remains, however, a "huge question" of whether early treatment blunts the long-term course of schizophrenia, he said.

Dr. McGlashan's study will continue for several years seeking answers to that question. The study was financed by the national health systems of Norway and Denmark. The extra cost of the early-detection effort amounted to about \$1 for each person living in the health districts, Dr. McGlashan said.

A PUZZLING DISORDER

Schizophrenia remains one of the most disabling and mysterious mental disorders

Prevalence: More than two million Americans suffer from the disease in a given year. Men and women are affected with equal frequency, but onset is usually earlier in men (early 20s) than women (mid-to-late 20s).

Causes: Unknown, although there is a genetic predisposition.

Symptoms: Psychotic or "positive" symptoms include delusions, hallucinations, disordered thinking. "Negative" symptoms include social withdrawal, extreme apathy, blunted emotional expression.

Treatment: Typically, patients need antipsychotic drugs in conjunction with psychotherapy or self-help groups to learn to develop social skills, cope with stress, identify relapse signs, etc.

Sources: *National Mental Health Information Center; National Institute of Mental Health*

Abstract from Archives of General Psychiatry

Reducing the Duration of Untreated First-Episode Psychosis Effects on Clinical Presentation

Ingrid Melle, MD; Tor K. Larsen, MD; Ulrik Haahr, MD; Svein Friis, MD; Jan Olav Johannessen, MD; Stein Opjordsmoen, MD; Erik Simonsen, MD; Bjørn Rishovd Rund, PhD; Per Vaglum, MD; Thomas McGlashan, MD

Arch Gen Psychiatry. 2004;61:143-150.

Context Most studies on first-episode psychosis show an association between a long duration of untreated psychosis (DUP) and poorer short-term outcome, but the mechanisms of this relationship are poorly understood.

Objective To determine whether it is possible to reduce the DUP for first-episode patients in a defined health care area through the introduction of an early detection (ED) program, compared with parallel health care areas without an ED program (No-ED).

Setting and Patients We included consecutive patients with a *DSM-IV* diagnosis of nonorganic, nonaffective psychosis coming to their first treatment in the study health care areas between January 1, 1997, and December 31, 2000. A total of 281 patients (76% of the total) gave informed consent.

Interventions The ED and No-ED health care areas offered an equivalent assessment and treatment program for first-episode psychosis. The ED area also carried out an intensive ED program.

Results The DUP was significantly shorter for the group of patients coming from the ED area, compared with patients from the No-ED areas (median, 5 weeks [range, 0-1196 weeks] vs 16 weeks [range, 0-966 weeks]). Clinical status measured by the Positive and Negative Syndrome Scale and the Global Assessment of Functioning Scale was significantly better for patients from the ED area at start of treatment and, with the exception of Positive and Negative Syndrome Scale positive subscale, at 3 months. Multiple linear regression analyses gave no indication that confounders were responsible for these differences.

Conclusions It is possible to reduce the DUP through an ED program. The reduction in DUP is associated with better clinical status at baseline that is maintained after 3 months.

From the Division of Psychiatry, Ullevaal University Hospital (Drs Melle, Friis, and Opjordsmoen), and the Institute of Psychology (Dr Rund) and Department of Behavioral Medicine (Dr Vaglum), University of Oslo, Oslo, Norway; Rogaland Psychiatric Hospital, Stavanger, Norway (Drs Larsen and Johannesen); Roskilde Psychiatric University Hospital Fjorden, Roskilde, Denmark (Drs Haahr and Simonsen); and Department of Psychiatry, Yale University School of Medicine, New Haven, Conn (Dr McGlashan).